State of West Virginia - Public Employees Insurance Agency
Retirement Health Benefits and Basic Life Insurance Enrollment Form

RET

Please read and follow the instructions included with this form when completing it. Use this form to enroll for health and basic life insurance coverage as a retiree. You **must** complete this form to continue your benefits as a retiree. This is a 2-page form. You must submit both pages for your enrollment to be valid. Incomplete forms will be returned and may delay your enrollment. Complete all sections of the form except the last section, "AGENCY", and return the completed form to your benefit coordinator.

RETIREE

Name (Last) (First) (MI) Generation -- Jr,, Sr. III)	Social Security Number	Medicare ID Number
Street Address	County of Residence	Home Phone ( )
City	State	Zip
Date of Birth (mm/dd/yyyy)	Sex (Check One) o M o F	I decline participation in any health or life insurance coverage. Signature Date

FAMILY INFORMATION

1) Provide the date when you were or when you will be entitled to Medicare coverage. Effective Date:_____. Please provide a copy of your Medicare ID Card if and when you are eligible for Medicare.

2) Provide the name of your last employer and your last day worked: _____

3) Complete the following information for all dependents who will be covered under your plan.

Name (Last, First, MI, Generation)	Address (if different from above)	Relationship (Circle One)	Sex (Circle One)	Birth Date (mm/dd/yyyy)	Social Security Number
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		

BASIC LIFE BENEFICIARY

Beneficiary Name (Last, First, MI, Generation)	Beneficiary Address (Street, City, State, Zip)	Social Security Number	Relationship to the Insured	Distribution % (Total Must Equal 100%)

COVERAGE

COVERAGE SELECTION (Select One)
I am enrolling for:

- ☐ Policyholder Only Health and Life Print the name of the plan you choose here: _____
- ☐ Family Health and Life Print the name of the plan you choose here: _____
- ☐ Life Insurance Only (NO health benefits)
- ☐ Life Insurance Only (health benefits under spouse's PEIA plan)
- ☐ Health Insurance Only (NO life insurance benefits)

EARNED EXTENDED BENEFITS
(Sick and/or Annual Leave Credits)
Complete if you have sick and/or annual leave credits.
I choose to use my credits to:

- ☐ Extend my employer-paid insurance overage. Please be aware that if the policyholder dies while using this benefit, survivors may continue coverage, but may not use any remaining accrued leave.
- ☐ Increase my annuity amount (Complete proper forms from CPRB).

Please be aware that if you submit conflicting documents regarding the use of your leave credits, the document you file with the CPRB will take precedence.

DEDUCTION AUTHORITY

- ☐ I authorize annuity deduction for any required premium beginning immediately after my earned extended coverage ends.
- ☐ I authorize annuity deduction for any required premium. I am not using leave credit for insurance.
- ☐ I DO NOT authorize annuity deductions. I request that my coverage terminate at the end of my earned extended coverage.

This form is continued on page 2. You must complete and return both pages of the form for it to be valid. Please continue.

Retirement Health Benefits and Basic Life Insurance Enrollment Form
Page 2

AFFIDAVITS

Tobacco Affidavit: Mark which members of the family (if any) use tobacco and sign the acceptance box below. If no one enrolled on your PEIA coverage uses tobacco, you will receive a premium discount on any PEIA PPB Plan health coverage and/or optional life insurance. I acknowledge by signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status.

Who uses tobacco: o Policyholder o Dependent (spouse and/or children) o No Tobacco Users within the last six (6) months

Living Will Affidavit: PEIA offers a premium discount to health policyholders who have executed a Living Will/Advance Directive. If you have a valid living will, please check the box beside the statement below and sign the form in the Acceptance box below.

o By checking this box, I acknowledge that I have executed a valid Living Will or advance directive, and that I have discussed its contents with the appropriate parties, including my family and my health care provider.

ACCEPTANCE

I hereby accept the group coverage I have indicated on this form. I understand that the PEIA may change the types or levels of benefits or the amount of contribution, and that the choices I have made may affect my contributions. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the health care plan I have selected, of all medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations.

Signature: Date:

AGENCY

Employer Information -- TO BE COMPLETED BY AGENCY BENEFIT COORDINATOR

Active Account Number | | | | | | | | | |

Retiree Account Number | | | | | | | | | |

Does the retiree remain on the Active Account? ☐ Yes ☐ No

Agency Name (optional): _____

Last Date of Active Employment | | / | | / | | | | |

Effective Date of Retirement | | / | | / | | | | |

Hire Date | | / | | / | | | | |

Effective Date of Retiree Insurance Coverage | | / | | / | | | | |

Number of days of accrued sick and annual leave for which the employee was not paid when employment ceased. | | | | |

Number of months of earned extended insurance coverage (2 days = 1 month single; 3 days = 1 month family coverage). Partial months are not allowed. | | |

Total WV State Government credited years of service: | |

Higher Education Faculty Only Total years of extended coverage (in months):
3-1/3 years service = 1 year single coverage; 5 years service = 1 year family coverage | | |

Member Retirement from: ☐ TIAA-CREF ☐ TRS ☐ TDC ☐ PERS

I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the applicant meets the minimum eligibility requirements for the Public Employees Insurance Plan.

Authorized Signature: Date:

Instructions for Retirement Health Benefits and Basic Life Insurance Enrollment Form

Please follow these instructions carefully when completing this form.

RETIREE

Complete ALL demographic information. The "Generation" area provides a space for men to indicate family generation indicators such as Jr., Sr., II, III, IV, etc.

The Medicare ID Number can be found on your red, white and blue Medicare card. This number is required for continued coverage when you reach Medicare age. If you are not yet eligible for Medicare, please send PEIA a copy of your Medicare card when you enroll for Medicare coverage.

If you ***do not*** wish to enroll for health or life insurance coverage as a retiree, sign and date the box stating "I decline participation ..." and return the form to your benefit coordinator.

FAMILY INFORMATION

1) We need information about Medicare coverage for you. Your premium decreases when you are retired and have Medicare. Please provide the date when you were or will become eligible for Medicare (typically age 65, unless you have a disability). When you become eligible for Medicare, it is important that you enroll for both Medicare Parts A and B. Please see your Summary Plan Description for more information.

2) We need information about your last employer prior to retirement and the last day that you worked (or will work) for that employer.

3) We need to know about any dependents to be covered under your health insurance. Please complete the chart. If adding a dependent, documentation is required showing that the dependent is eligible for coverage. See the documentation memo for details.

BENEFICIARY

Your health insurance includes a basic decreasing term life insurance policy on you. Please designate the beneficiary(s) of this basic term life insurance policy in the "Basic Life Insurance Beneficiary" section. Please consult your insurance coordinator if you have questions about the amount of life insurance coverage you have. The life insurance proceeds will be distributed equally among all designated beneficiaries unless you specify otherwise on this form. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who dies before the policyholder will be distributed equally among all surviving named beneficiaries. If no beneficiary survives the employee, payment will be made in accordance with the terms of the policy. The name of the beneficiary should be written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. A. Doe."

COVERAGE

Coverage Selection: Please indicate the type of coverage you choose to have in retirement. Remember that if you are continuing your health care coverage into retirement, you must remain the health care plan you were in as an active employee through the end of the plan year (June 30), unless you were in a managed care plan and will be Medicare-eligible when you retire. Please be sure to fully specify the plan you want, including the plan name and any option, such as PEIA PPB Plan A or The Health Plan Plan B. For life insurance, on this form, you can continue your basic life insurance. If you wish to continue Optional and/or Dependent coverage, you must complete the Retiree Optional Life Insurance form.

Earned Extended Benefits: If you have sick and/or annual leave credits, you must specify how you want to use those credits. You may use them to extend your employer-paid coverage under PEIA or to increase your annuity from CPRB. For details, please see your Summary Plan Description. If you were hired after July 1, 2001, you cannot use sick/annual leave credits to extend employer-paid insurance coverage. You will have the opportunity to indicate how you would like to use your leave credits on this form, and on your retirement form from CPRB. If you file conflicting documents, then whatever you mark on the CPRB form is what will be done. For example, if you mark here that you want to use your leave for health insurance, and you mark your retirement forms saying you want to use your accrued leave to increase your annuity, then your annuity will be increased, and you will pay monthly premiums from that annuity for whatever coverage you have chosen on this form.

Deduction Authority: Please indicate how you will pay your premiums by checking the appropriate box.

AFFIDAVITS

PEIA offers discounts to tobacco-free plan members for both health and optional life insurance. You must complete the affidavit to qualify for the discounts. PEIA also offers a discount to health policyholders who have executed a living will or advance directive. If you have such a document, please complete the affidavit.

ACCEPTANCE

When you have made your selections on this form, you must sign and date the "Acceptance" box.

COMPLETING THE PROCESS

When your form is complete, return it to the benefit coordinator at your place of employment (or to the PEIA, if you are already retired). Your benefit coordinator will complete the Agency portion of the form and submit it for processing.